



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Avant Medical Group

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-11-1261-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

January 18 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our doctors usually spend 25-30 minutes conducting a re-evaluation of established patients. As noted in the typed subsequent report that was submitted with the HCFA billing you can clearly note that a comprehensive history is documented under Present Medical Condition on our follow-up exam form. A comprehensive examination including neuro & ortho exams were also performed and documented in the exam form. Decision making of moderate complexity was also met and documented in the treatment plan. Plan is noted in the report as well as discussing current medication and referral recommendations..."

Amount in Dispute: \$221.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute. 1. The compensable injury is to the left wrist. The requestor's documentation of its 99214 E&M service entails the cervical and lumbar spines along with very little clinical information of the left wrist. 2. There was no significant change in the claimant's status as represented by the DWC-734, code 99080. 3. The requestor did not indicate on the DWC-59 either agreement or disagreement with the certification of maximum medical improvement and with the impairment rating assigned by the certifying doctor. For these reasons Texas Mutual declined to issue payment and believes no payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 19, 2010	99214, 99080, 99455	\$221.00	\$15.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.307, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes filed prior to June 1, 2012
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for E/M services

The services in dispute were reduced/denied by the respondent with the following reason codes:

- CAC - 150 Payer deems the information submitted does not support this level of service.
- CAC-16 Claim/service lacks information which is needed for adjudication at least one remark code must be provided.
- 225 – The submitted documentation does not support the service being billed.
- 890– This level of service is being disputed as it does not meet the components as defined in the “CPT Book”.
- 892 – Denied in accordance with DWC Rules and/or medical fee guidelines
- 248 – DWC-73 not properly completed or submitted in excess of the filing requirements. Reimbursement denied per rule 129.5

Issues

1. Did the requestor meet the requirements of 28 Texas Administrative Code §134.203?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, “for coding, billing reporting, and reimbursement of professional medical services, Texas Workers’ Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; ... and other payment policies in effect on the date a service is provided...” Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient. The American Medical Association (AMA) CPT code description for 99214 is:

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

The 1997 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare policy. It describes the documentation requirements for the service in dispute. Review of the documentation finds the following:

- Documentation of the Detailed History
 - History of Present Illness (HPI) consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions. Documentation found listed three chronic conditions, (L UE L hand, Cervical and Lumbar) thus meeting this component.
 - Review of Systems (ROS) requires two to nine systems to be documented. Documentation found listed tree systems, (cervical spine, lumbar spine, wrist) this component was met.
 - Past Family, and/or Social History (PFSH) requires at least one specific item from any three history areas to be documented. The documentation found listed one area (Past treatments). This component was met.
- Documentation of a Detailed Examination:
 - Requires at least six organ systems to be documented, with at least two elements per listed system. The documentation found listed 2 body/organ systems: (constitutional, musculoskeletal). This component was not met.

The division concludes that the documentation does not sufficiently support the level of service billed.

The division notes that code 99080 was also listed in the table of disputed services. Pursuant to 28 Texas Administrative Code §129.5 reimbursement in the amount of \$15.00 is recommended as the employee's work status and activity restrictions were identified.

Code 99455 VR was also included on the table. 28 Texas Administrative Code §134.204 (j)(3)(A)(i) details the billing requirements for MMI evaluations. No documentation was found to support that an impairment rating was reached. No payment can be recommended.

2. For the reasons stated above, the preparation of the Work Status Report is eligible for payment pursuant to 28 TAC §129.5. However, the remaining services were not supported by documentation. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$15.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$15.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	September 3, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.